



DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Tuition Waiver Reimbursement Procedure

Fill out **TUITION WAIVER FORM** in its entirety.

Must have Semester bill showing the number of credits and total tuition amount.

**SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY
STATE UNIVERSITY OF NEW YORK
HEALTH SCIENCE CENTER AT BROOKLYN
UNIVERSITY HOSPITAL OF BROOKLYN**

**NURSES WHO ARE INTERESTED IN THE TUITION WAIVER PROGRAM MUST
COMPLETE THE FOLLOWING ITEMS:**

1. Name: _____
Last First Middle
2. Social Security Number: _____
3. Mailing Address: _____
4. Telephone Number: Home: _____ Work: _____
5. Employment Status: _____ Full Time: _____ Part Time: _____ Other: _____
6. Date of Employment at UHB: _____
7. Current Professional License Information:
#: _____ State: _____
8. Have you previously applied to the SUNY, HSCB, College of Nursing?
_____ No _____ Yes For entry in 20 _____
9. Are you currently enrolled in the SUNY, HSCB, /College of Nursing?
_____ Yes _____ Non Matriculated _____ Yes _____ Non Preparatory _____ Yes
10. Are you currently enrolled in a College/University? _____ Yes _____ No
If Yes, Name of College/University: _____
Program: _____
11. If interested in a Tuition Waiver Program, please indicate:
a) For entry in 20 _____ Fall _____ Spring _____ summer _____
b) Degree Program you wish to pursue: _____

**PLEASE SUBMIT THIS INFORMATION TOGETHER WITH YOUR LETTER OF ACCEPTANCE FROM
SUNY, HSCB, COLLEGE OF NURSING TO:**

**INSTITUTE OF CONTINUOUS LEARNING, BOX 1216
FOR FURTHER INFORMATION, PLEASE CALL: 718-270-2983**